

RSC Policy Brief: Social Security and Medicare Trustees Report

August 5, 2010

Today, the Social Security and Medicare Trustees released their annual reports (click [here](#) for the summary) on the state of the Social Security and Medicare trust funds. Below you will find background information and a summary of the [Medicare Trustees Report](#). However, as “the projections shown in the report do not represent the ‘best estimate’ of actual future Medicare expenditures” – due to the substantial number of caveats and unrealistic and unsustainable cuts under PPACA – CMS actuaries have prepared an alternative scenario, found [here](#).

Background

Although the report must be approved by the Medicare Board of Trustees (composed mostly of political appointees from the Obama administration), the report itself is written, for the most part, by CMS’s Chief Actuary, Richard Foster.

In an April report titled the “Estimated Financial Effects of the *Patient Protection and Affordable Care Act* (PPACA) as Amended”, Foster [found](#) that although Medicare cuts in PPACA would lower the exhaustion date of the HI (Hospital Insurance) trust fund, “in practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.”

Not only can you not double count the Medicare savings, but Foster also [found](#) that “reductions in Medicare payment updates to Part A providers, based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis,” and “the actual HI savings from these provisions would be less than estimated, and the postponement in the trust fund exhaustion date would be shorter.”

Finally, [CBO](#) also dismantled the Democrats’ claims when it found:

The savings to the HI trust fund under PPACA would be received by the government *only once* [emphasis added], so they cannot be set aside to pay for future Medicare spending [thus increasing its solvency] and, at the same time, pay for current spending on other parts of the legislation or on other programs....To describe the full amount of HI trust fund savings as both improving the government’s ability to pay future Medicare benefits and financing new spending

outside of Medicare would essentially double-count a large share of those savings and thus overstate the improvement in the government's fiscal position.

Regardless of “traditional accounting rules” deployed by the latest Trustees Report - the massive cuts to Medicare in the bill ([\\$528.9](#) billion to be exact) are not used to improve the program's solvency, but instead spent on new entitlement spending and government programs. The truth is either you're extending the life of Medicare or you're paying for the bill. You can't claim both. [CBO agrees](#).

Summary

Below are some of the *highlights* of the findings of the Trustees Report:

Medicare

- Medicare began running a cash flow deficit in 2008.
- The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003. (Page 5)
- This year marks the 5th straight year that the Trustees have issued a “Medicare funding warning” as “federal general revenues are becoming a substantial share of total financing for Medicare.” This funding warning is issued when Medicare spending - not funded by payroll taxes or beneficiary premiums / co-pays - exceeds 45% of all Medicare Spending. (Page 6)
 - Already this Congress the Democrats' rules package has turned off the Medicare Trigger, a funding warning mechanism put in place by conservatives in the Medicare Modernization Act of 2003 (MMA) as a means to force consideration of spending reform if for two consecutive years, 45% or more of Medicare's funding comes from general tax revenues.
- Medicare trust fund reaches exhaustion (insolvency):
 - 2029 - Assuming you double count Medicare and the unsustainable and unlikely cuts actually occur. (Page 5)
- Medicare unfunded obligations projections for 75-year budget window:
 - \$30.8 trillion. (Page 244)

Caveats

“If Congress continues to override the statutory decreases in physician fees, and if the reduced price increases for other health services under Medicare become unworkable and do not take effect in the long range, then Medicare spending would instead represent roughly 11.0 percent of GDP in 2084. Growth of this magnitude, if realized, would substantially increase the strain on the nation's workers, the economy, Medicare beneficiaries, and the Federal Budget.” (Page 8)

Actuarial Analysis:

“The actual future costs for Medicare are likely to exceed those shown by the current-law projections in this report.” (Page 43)

Medicare Financial Projections:

“When interpreting these projections, however, it is important to understand that projected Part B, SMI, and total Medicare expenditures are unrealistically low in 2010 and later because of the current-law physician payment reductions. Should these payment rates, by new legislation, be prevented from declining, the overall Medicare costs shown in this section would be increased—possibly by about 6 to 9 percent in the short range, depending on the specific changes enacted. If, in addition, the productivity adjustments to other Medicare price increases are phased out after 2019, then total Medicare costs in 2030 could be roughly 18 percent greater than shown in table III.A2, 38 percent greater in 2050, and 69 percent greater in 2080.” (Page 47)

Medicare Advantage:

“In 2009, enrollment in private health plans represented 24 percent of total Medicare beneficiaries, with nearly all such enrollees participating in Medicare Advantage health insurance plans. Enrollment in MA plans is expected to decline in the future, both in number and as a percent of total beneficiaries. As noted, the Affordable Care Act reduces Medicare payments to private plans, which will result in less-generous plan benefit packages and/or higher premiums. By 2017 when these changes are fully phased in, an estimated 15 percent of Medicare beneficiaries would remain in private Part C health plans, with the balance reverting back to traditional ‘fee-for-service’ Medicare. Ultimately, the proportion of beneficiaries in such plans is estimated to stabilize at just under 13 percent.” (Page 49)

Statement of Actuarial Opinion:

“Further, while the Patient Protection and Affordable Care Act, as amended, makes important changes to the Medicare program and substantially improves its financial outlook, there is a strong likelihood that certain of these changes will not be viable in the long range.”

- “While the Part B projections in this report are reasonable in their portrayal of future costs under current law, they are not reasonable as an indication of actual future costs. Current law would require physician fee reductions totaling an estimated 30 percent over the next 3 years—an implausible result.”
- “Specifically, the annual price updates for most categories of non-physician health services will be adjusted downward each year by the growth in economy-wide productivity. The best available evidence indicates that most health care providers cannot improve their productivity to this degree—or even approach such a level—as a result of the labor-intensive nature of these services.” (Page 281)

“For these reasons, the financial projections shown in this report for Medicare **do not represent a reasonable expectation** for actual program operations in either the short range (as a result of the unsustainable reductions in physician payment rates) or the long range (because of the strong likelihood that the statutory reductions in price updates for most categories of Medicare provider services **will not be viable**).” (Page 282)

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